2009 Summary of Medical Benefits—IBEW Local 77

This summary is intended to assist you in decision making. Details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract.

Group Health Cooperative (GHC) Standard Plan	City of Seattle Traditional		City of Seattle Preventive	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible (per calendar year)				
Does not apply	$100 per person, $300 per family	$150 per person, $450 per family	Does not apply	$250 per person, $750 per family
Annual Out of Pocket (OOP) Maximum (excluding deductible if applicable)				
$750 per person, $1,500 per family	$200 per person – applies to 20% coinsurance	$1,200 per person - applies to 40% coinsurance	$500 per person $1,000 per family (applies to emergency room copays)	$3,000 per person $6,000 per family Most costs paid in full after out-of-pocket maximum is paid.
Maximum Lifetime Benefits Payable				
None	$1,000,000		$1,000,000	$1,000,000
Inpatient Pre-Admission Authorization				
Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission.		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
Choice of Providers				
All care and services must be approved and/or provided by GHC or GHC designated providers.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.
	Outside the service area: Any licensed, qualified provider. Expenses paid based on Reasonable and Customary (R&C)* charges. You pay the difference between R&C and billed charges.			

Group Health Cooperative (GHC) Standard Plan	City of Seattle Traditional		City of Seattle Preventive	
	In-Network	Out-of-Network	In-Network	Out-of-Network
COVERED EXPENSES				
Acupuncture				
Paid at 100% after $5 copay with physician's referral for certain conditions.	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
Maximum of eight visits per condition per calendar year.	Maximum of 12 visits per calendar year. Maximum does not include acupuncture treatment for chemical dependency.			
Ambulance Service				
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary		Ground ambulance paid at 100% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Chemical Dependency Treatment (alcohol/drug addiction)				
Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay	Paid at 80%		Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay	Inpatient: Paid at 70% Outpatient: Paid at 70%
Combined benefit maximum of $14,500 per 24 month period for inpatient and outpatient services	Combined benefit maximum of $14,500 per 2-year period for inpatient and outpatient services, and preferred and participating services.		Combined benefit maximum of $14,500 per 24 month period for in-network and out-of-network services	
Contraceptives				
Contraceptive drugs and devices: see Prescription Drug benefit.	Oral contraceptive drugs: see Prescription Drug benefit. Contraceptive devices and other prescription contraceptive products covered as medical benefit.	Oral contraceptive drugs: not covered. Contraceptive devices and other prescription contraceptive products covered as medical benefit.	Oral contraceptive drugs: see Prescription Drug benefit. Contraceptive devices and other prescription contraceptive products covered as medical benefit.	Oral contraceptive drugs: not covered. Contraceptive devices and other prescription contraceptive products covered as medical benefit.
Durable Medical Equipment				
Paid at 80%	Paid at 80%		Paid at 100%	Paid at 70%
	Maximum benefit unlimited for in-network and out-of-network combined.		Maximum benefit unlimited for in-network and out-of-network combined.	
Emergency Room Services				
GHC facility: Paid at 100% after $50 copay (waived if admitted) Non-GHC facility: Paid at 100% after $100 deductible (waived if admitted)	Paid at 80%.	Paid the same as in-network except if it's non-emergency, then it's 60%	Paid at 100% after $50 copay (waived if admitted.) Urgent Care paid at 100% after $35 copay.	Paid the same as in-network except if it's non-emergency, then it's 70% after $50 copay. (waived if admitted). Urgent care paid at 70%. Urgent Care is paid at 100% after $35 copay.

Group Health Cooperative (GHC) Standard Plan	City of Seattle Traditional		City of Seattle Preventive	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice				
Paid at 100% when authorized	Paid at 90%. Lifetime maximum of 6 months. 14 day inpatient limit. 120 hour limitation for skilled nursing care.		Paid at 100% Maximum of 6 months for inpatient and outpatient combined.	Not covered
Maternity Care (Inpatient)				
Delivery and related hospital.. Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maternity Care (Outpatient)				
Paid at 100% after $5 copay	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
Mental Health Care (Inpatient)				
Paid at 100%.	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Mental Health Care (Outpatient)				
Paid at 100% after $5 copay per individual, family or couple session. Copays apply to the annual out-of-pocket maximum.	Paid at 50%. Coinsurance does not apply to the annual out-of-pocket maximum.		Paid at 100% after $5 copay Copays do not apply to the annual out-of-pocket maximum.	Paid at 70% Coinsurance applies to the annual out-of-pocket maximum.
Neurodevelopmental Therapy (for children under age 7)				
Covered under Rehabilitation benefit.	Paid at 80%		Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay.	Paid at 70%. Coinsurance applies to the annual out-of-pocket maximum.
	Maximum of $2,000 per calendar year for preferred and participating services combined. Coinsurance does not apply to the out-of-pocket maximum.		Maximum of $3,000 per calendar year for in-network and out-of-network combined.	
Physician and Hospital Services (Inpatient)				
Inpatient: Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Physician and Hospital Services (Outpatient)				
Paid at 100% after $5 copay for most visits	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay per visit	Paid at 70%

Group Health Cooperative (GHC) Standard Plan	City of Seattle Traditional		City of Seattle Preventive	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs (retail)				
For a 30-day supply: $5 copay. Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 34-day supply or 100 unit supply (whichever is greater): $8 copay. You pay the difference between generic and name-brand. Oral contraceptives are covered. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit. Copays do not apply to out-of-pocket maximum. Non-formulary drugs not covered.	Not Covered	For a 31-day supply: Generic: $5 copay Preferred brand name: $10 copay Non-preferred drugs: $25 copay Oral contraceptives are covered. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit. Copays do not apply to out-of-pocket maximum.	Not covered
Prescription Drugs (mail order)				
3x $5 copay per 90-day supply	For a 90-day supply: $16 copay. Non-formulary drugs are not covered	Not Covered	For a 90-day supply: Generic: $10 copay Preferred brand name: $20 copay Non-preferred drugs: $50 copay	Not Covered
Preventive Care				
Paid at 100% for preventive care visits, most immunizations, hearing exams, eye exams and mammograms.	Paid at 100% (deductible waived) Maximum of $300 per calendar year. Mammograms paid at 80%.	Paid at 60% for mammograms, deductible waived.	Paid at 100% for periodic check-ups, well child care, immunizations, well woman care and mammograms.	Paid at 70% for well woman care and mammograms. No other preventive services covered.
	Mammograms limited to one per year for preferred and participating services combined and not applied to $300 maximum.			

Group Health Cooperative (GHC) Standard Plan	City of Seattle Traditional		City of Seattle Preventive	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Rehabilitation Services (Inpatient)				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maximum of 60 days per condition per calendar year for all types of rehabilitation.	Maximum of $50,000 per condition per calendar year for preferred and participating services combined.		Maximum of 120 days per calendar year for in-network and out-of-network combined.	
Rehabilitation Services (Outpatient)				
Paid at 100% after $5 copay	Paid at 80%		Paid at 100% after $5 copay	Paid at 70%
Maximum of 60 days per condition per calendar year for all types of rehabilitation.	Coinsurance does not apply to out-of-pocket maximum. Maximum calendar year benefit of $2,000.		Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Coinsurance does apply to the annual out-of-pocket maximum. Maximum of 20 visits per calendar year for each of the above listed benefits for in-network and out-of-network combined.	

Group Health Cooperative (GHC) Standard Plan	City of Seattle Traditional		City of Seattle Preventive	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Skilled Nursing Facility				
Paid at 100%; 60 day maximum per calendar year (in addition to coverage in lieu of hospitalization).	Paid at 80%		Paid at 100%	Paid at 70%
	Maximum of 90 days per calendar year.		Maximum of 120 days per calendar year for in-network and out-of-network combined.	
Smoking Cessation				
Paid at 100% for individual/group sessions. Nicotine replacement therapy included in Prescription Drugs benefit. No copay on all smoking cessation prescription drugs.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail.	Not covered.	Not covered	
Spinal Manipulations				
Paid at 100% after $5 copay. Self-referral to GHC designated providers. Must meet GHC protocol.	Paid at 80%		Paid at 100% after $5 copay.	Paid at 70%
Maximum of 10 visits per calendar year.	Maximum of 10 visits per calendar year.		Maximum of 20 visits per calendar year for in-network and out-of-network combined.	
Sterilization Procedures				
Vasectomy and tubal ligation covered subject to applicable copayment	Paid at 80%	Paid at 60%	Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay.	Paid at 70%
Temporomandibular Joint (TMJ) Services				
Inpatient: Paid at 100%. Outpatient: Paid at 100% after $5 copay. Maximum benefit of $1,000 per calendar year/$5,000 lifetime for inpatient and outpatient combined.	Not covered		Not covered	
Tooth Injury due to accident				
Not covered	Paid at 80% Services of dentist or denturist covered based on R&C charges up to 12 months from injury date to a maximum of $600. Physician and hospital benefits provided if inpatient care needed.		Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay.	Paid at 70%
			Services of dentist or denturist covered based on R&C charges up to 12 months from injury date. Physician and hospital benefits provided if inpatient care needed.	

Group Health Cooperative (GHC) Standard Plan	City of Seattle Traditional		City of Seattle Preventive	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Travel Outside of Country				
Emergency: Paid at 100% after $100 deductible. Waived if admitted. Non-emergency: Not covered.	Emergency paid at 80%. Non-emergency paid at 60%		Not applicable	Paid at 100% after applicable office, or emergency room copay.
				Paid at 70% after applicable copay for non-emergency
Vision Hardware				
Covered under Vision Service Plan	Covered under Vision Service Plan.		Covered under Vision Service Plan	
Wellness Tools				
On line health profile to determine health risks. Health report and recommendations based on profile. Unlimited lifestyle coaching. Group Health Medical Records: All claims are included in the member's permanent record. Health profile data is integrated into the electronic medical record.	On line health profile to determine health risks. Health report and recommendations based on profile. No lifestyle coaching. Personal Health Record: Medical information is automatically populated based on claims data submitted. Targeted messages, alerts, and reminders via each individual's record.	N/A	On line health profile to determine health risks. Health report and recommendations based on profile. No lifestyle coaching. Personal Health Record: Medical information is automatically populated based on claims data submitted. Targeted messages, alerts, and reminders via each individual's record.	N/A
X-ray and Lab Tests				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%

* Applies to Aetna - Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.
^ Applies to Aetna – Aexcel network, a specialty network of doctors in the 13 specialty areas. The coinsurance level will drop 10% for non-Aexcel doctors in the 13 specialty areas (coinsurance applies to in-network, out-of-pocket maximum).
This summary is intended to assist you in decision making. Details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract.